Republic of the Philippines
Department of Education
REGION III
SCHOOLS DIVISION OFFICE OF BATAAN

JUL 09 2025

DIVISION MEMORANDUM
No. 285 s. 2025

SUBMISSION OF MEDICAL ALLOWANCE REGISTRATION FORM

To: Assistant Schools Division Superintendent
Chief Education Supervisors
Public Schools District Supervisors
Elementary and Secondary School Principals
Administrative Officer II
All Others Concerned

1. In compliance with **DepEd Memorandum No. 16, s. 2025**, all teaching and non-teaching personnel are required to **fill out the Medical Allowance Registration Form** for the School Year 2025-2026, and submit it to this Office on or before July 11, 2025.

2. Kindly take note of the following important reminders:

   A. Submission to Division Office: The forms will be **transmitted to the Division Office** through a **district-level consolidation** along with the required transmittal, at the Personnel Unit.

   B. There should be a separate folder for the teaching and non-teaching Personnel of the respective school.

   C. The submission shall be plantilla-based

3. The field's full cooperation is expected to ensure timely and complete submission. Should there be any questions or need assistance in filling out the form, feel free to contact Ma. Liza A. Manuel, HRMO at 09206249675/09951316507

4. For immediate dissemination and strict compliance.

CAROLINA S. VIOLETA, EdD, CESO V
Schools Division Superintendent

S1/AD5

Annex A

Medical Allowance Registration Form

Data Privacy Notice: The Department of Education recognizes its responsibility under the Republic Act No. 10173, otherwise known as the *Data Privacy Act of 2012*, with respect to the data they collect, record, organize, update, use, consolidate or destruct from their personnel. The personal data obtained from this form is entered and stored within the organization's authorized information and communications system and will only be accessed by authorized personnel. The organization has instituted appropriate technical and physical security measures to ensure the protection of personal data.

Furthermore, the information collected and stored in the portal shall only be used for the purposes of this activity. DepEd shall not disclose any personal information without consent and shall retain this information over a period of (10) ten years for the effective implementation and management of its activities.

Employee Information

Full Name: _____
Employee ID Number: _____
Position/Designation: _____
Office: _____
Date of Appointment (dd/mm/yyyy): _____

Sex: _____ Date of Birth (dd/mm/yyyy): _____
Mobile Number: _____ Email: _____

For Non-teaching personnel
Region: _____
Division: _____
School: _____
Employment Status: ☐ Permanent ☐ Contractual
☐ Casual ☐ Substitute

Form of Availment
*Kindly select **one:***

Group
☐ Agency Procurement

Individual
☐ Payroll Disbursement for availment of new/renewal of individual HMO
☐ Cash form for payment of medical expenses

Certification

I hereby confirm that the information provided above id accurate and truthful. I agree to comply with the terms and conditions outlined in the Guidelines on the Grant of medical allowance to DepEd personnel, including the submission of required documents for verification and processing.

Employee's Signature: _____ **Date:** _____

Annex A

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Employee Information

Full Name: _____
Employee ID Number: _____
Position/Designation: _____
Office: _____
Date of Appointment (dd/mm/yyyy): _____

Sex: _____ Date of Birth (dd/mm/yyyy): _____
Mobile Number: _____ Email: _____

For teaching personnel
Region: _____
Division: _____
School: _____
Employment Status: ☐ Permanent ☐ Contractual ☐ Casual ☐ Substitute

Form of Availment

*Kindly select **one:***

Group
- ☐ Agency Procurement

Individual
- ☐ Payroll Disbursement for availment of new/renewal of individual HMO
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